Utah Department of Health

Insurance Payment Report
Claim Attachment

UTAH DEPARTMENT OF HEALTH
MEDICAID FORM

PATIENT INFORMATION

1 Last Name:	2 First Name:	3 Middle Name:
4 Medicaid ID Number:	5 Date of Birth:	6 Gender: Male ☐ Female ☐ Unknown ☐

PROVIDER INFORMATION

7 Provider or Organization Name:	8 Medicaid Provider ID:

OTHER PAYER INFORMATION

9 Other Payer Name:		10 Medicare Carrier: Yes ☐ No ☐	16 Payer Responsibility: Primary ☐ Secondary ☐ Tertiary ☐
11 Street Address:		12 City:	
13 State:	14 ZIP:	15 Phone Number: ( )	
17 Group or Policy Number:		18 Other Payer Claim Number:	

CLAIM LEVEL - INFORMATION

19 Date(s) of Service:	20 Date of Claim Adjudication:	21 Total Charge: $
22 Payer Allowed: $	23 Payer Paid: $	24 Patient Resp: $

Claim Adjustment Reasons

25a Remark Code:	b Remark Code:	c Remark Code:	d Remark Code:	e Remark Code:

26 Group Code: OA	a Reason:	b Reason:	c Reason:	d Reason:	e Reason:	f Reason:
27 Group Code: PR	a Reason:	b Reason:	c Reason:	d Reason:	e Reason:	f Reason:
28 Group Code: CO	a Reason:	b Reason:	c Reason:	d Reason:	e Reason:	f Reason:
29 Group Code: CR	a Reason:	b Reason:	c Reason:	d Reason:	e Reason:	f Reason:
30 Group Code: PI	a Reason:	b Reason:	c Reason:	d Reason:	e Reason:	f Reason:

LINE LEVEL - INFORMATION

31 Line	32 Date	33 Procedure	34 Charge	35 Allowed	36 Payer Paid	37 Deductible	38 Coins/Copay	39 Noncovered	40 Adj. Code

UDOH-DHCF-COB 4/03

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(Additional Page)

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OTHER PAYER INFORMATION

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LINE LEVEL - INFORMATION (Continued)

31 Line	32 Date	33 Procedure	34 Charge	35 Allowed	36 Payer Paid	37 Deductible	38 Coins/Copay	39 Noncovered	40 Adj. Code